

5616 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHARLOTTE HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phys Mem. Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Marie BARBER</u>		4. DATE OF DEATH Month Day Year <u>5</u> <u>13</u> <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-58</u>
9. AGE (In years lost birthday) yrs. <u>12</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES ELWOOD BARBER</u>		14. MOTHER'S MAIDEN NAME <u>ALICE LUCILLE BUTLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>14 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21. I certify that I attended the deceased from <u>5-13</u> , 19 <u>58</u> , to <u>5-13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-13</u> , 19 <u>58</u> , and that death occurred at <u>2:00</u> P.M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Tr Johnson</u>	DATE SIGNED <u>5-13-58</u>
PHYSICIAN'S NAME (Type) <u>La Plata Md.</u>	ADDRESS (Street, city or town, state) <u>La Plata Md.</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Bryantown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md</u>		24a. REC'D BY REGISTRAR <u>MAY 15 58</u>	24b. REGISTRAR'S SIGNATURE <u>Aw. L. Smith</u>

4000194XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05608

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> 5617 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemoy</u> c. LENGTH OF STAY IN lb <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pomon Key</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomon Key</u> d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Franklin BRAWNER</u>		4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>1958</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>April 13 1913</u> 9. AGE (In years last birthday) <u>45</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert Clinton Browner</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Toye</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-8323</u>		17. INFORMANT <u>Robert C. Browner</u> Address <u>Indian Head, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5-15-58</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-15-58</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>5/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Charles</u>	
22d. LOCATION (City, town, or county) <u>Glymont</u> (State) <u>Md.</u>		24a. REC'D BY REGISTRAR <u>May 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		ADDRESS _____			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 6.9 Film G229 6-3-58 et

CERTIFICATE OF DEATH

05609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodside</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodside</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HATTIE REBECCA BROWN</i>		4. DATE OF DEATH <i>May 19 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 23, 1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Bowie Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joshua Barnes</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Carter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Indicate, no. or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>4200</i>	
17. INFORMANT <i>Eleanor Boswell</i>		Address <i>Baltimore Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia, Terminal</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Congestive Heart Failure</i> (c) <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i> <i>1 year</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491X</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>— 19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-15-58</i> , 19 <i>58</i> , to <i>5-18-58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5-15-58</i> , 19 <i>58</i> , and that death occurred at <i>12:30 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J B Dettor</i>		ADDRESS (Street, city or town, state) <i>La Plata, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>V.B. DETTOR</i>		DATE SIGNED <i>5/18/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/21/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Shilo M.C.</i>		22d. LOCATION (City, town, or county) (State) <i>Woodside Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William E. LaPlata</i>		ADDRESS <i>LaPlata, Maryland</i>	
24a. REC'D BY REGISTRAR <i>May 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur</i>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: JAMES H. [illegible]]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45 years]</p>		<p>4. RACE [Handwritten: White]</p>	
<p>5. DATE OF DEATH [Handwritten: May 15, 1945]</p>		<p>6. TIME OF DEATH [Handwritten: 10:30 AM]</p>		<p>7. PLACE OF DEATH [Handwritten: Home]</p>		<p>8. COUNTY [Handwritten: Baltimore]</p>	
<p>9. CAUSE OF DEATH [Handwritten: Myocardial infarction]</p>		<p>10. MANNER OF DEATH [Handwritten: Natural]</p>		<p>11. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>		<p>12. DATE OF BIRTH [Handwritten: May 15, 1900]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Handwritten: J. H. [illegible]]</p>		<p>14. SIGNATURE OF REGISTRAR [Handwritten: [illegible]]</p>		<p>15. SIGNATURE OF DECEASED [Handwritten: [illegible]]</p>		<p>16. SIGNATURE OF WITNESSES [Handwritten: [illegible]]</p>	



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rome</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>Issue</u>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE William CAMPBELL</u>		4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alec CAMPBELL</u>		14. MOTHER'S MAIDEN NAME <u>DENNIE CAMPBELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>ISSE</u> Address <u>MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vas. Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5-8-58</u> <u>1954</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		22d. LOCATION (City, town, or county) (State) <u>Issue, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNTT Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 12 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Out. Keenich</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
RESIDENCE		OCCUPATION		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION		TIME OF EXAMINATION	
FAMILY HISTORY		PREVIOUS ILLNESS		POST-MORTEM	
TOXICOLOGY		LABORATORY TESTS		HISTOPATHOLOGY	
RADIOLOGY		MICROBIOLOGY		IMMUNOLOGY	
PHARMACOLOGY		CLINICAL CHEMISTRY		HEMATOLOGY	
NEUROLOGY		PSYCHIATRY		PEDIATRICS	
GERIATRICS		OBSTETRICS		GYNACOLOGY	
UROLOGY		ENT		OPHTHALMOLOGY	
DENTISTRY		PLASTIC SURGERY		ORTHOPEDICS	
ONCOLOGY		CARDIOLOGY		PULMONOLOGY	
NEPHROLOGY		ENDOCRINOLOGY		IMMUNOLOGY	
INFECTIOUS DISEASES		ALLERGY		TRANSFUSION MEDICINE	
REPRODUCTIVE MEDICINE		PAIN MANAGEMENT		PALLIATIVE CARE	
EMERGENCY MEDICINE		CRITICAL CARE		SUPPORTIVE CARE	
REHABILITATION		MENTAL HEALTH		SUBSTANCE ABUSE	
PUBLIC HEALTH		Epidemiology		Biostatistics	
Environmental Health		Occupational Health		Community Health	
Health Services Research		Health Economics		Health Law	
Health Policy		Health Equity		Health Communication	
Health Promotion		Health Behavior		Health Systems	
Health Management		Health Quality		Health Improvement	
Health Research		Health Innovation		Health Leadership	
Health Education		Health Training		Health Development	
Health Evaluation		Health Monitoring		Health Assessment	
Health Planning		Health Implementation		Health Maintenance	
Health Protection		Health Promotion		Health Prevention	
Health Surveillance		Health Investigation		Health Control	
Health Intervention		Health Evaluation		Health Impact	
Health Research		Health Innovation		Health Leadership	
Health Education		Health Training		Health Development	
Health Evaluation		Health Monitoring		Health Assessment	
Health Planning		Health Implementation		Health Maintenance	
Health Protection		Health Promotion		Health Prevention	
Health Surveillance		Health Investigation		Health Control	
Health Intervention		Health Evaluation		Health Impact	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 File 6229 6-1-58 et

5620

CERTIFICATE OF DEATH

05611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Waldorf</u>				c. LENGTH OF STAY IN 1b <u>48 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RR-1 - Waldorf Md</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SIMON</u> Middle <u>EPP</u> Last <u>EPP</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 3, 1863</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Daniel Epp</u>		14. MOTHER'S MAIDEN NAME <u>Amelia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Son - Leonard Epp - Waldorf Md</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho Pneumonia</u> <u>491X</u> DUE TO <u>Upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Wetshred Secondary to operation</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 days</u> <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Intestinal Surgery - 4/24/58</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>Apr 28, 1958</u> , to <u>May 26, 1958</u> , that I last saw the deceased alive on <u>May 26, 1958</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vahel M. Seron</u> M.D. <u>Waldorf Md</u>				ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>5/26/58</u>			
PHYSICIAN'S NAME (Type) <u>VAHEL M. SERON M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05612

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

5621

Item 9 Film 228 5-15-58 et

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		c. LENGTH OF STAY IN 1b 70x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS 1210 Glenn Street	
3. NAME OF DECEASED (Type or print) First HARRY Middle Thomas Last FIELDS		4. DATE OF DEATH Month May Day 6 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17, 1914
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19	
11. BIRTHPLACE (State or foreign country) Virginia W.Sa		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ora Downing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or as indicated) No		16. SOCIAL SECURITY NO. James Moyo Laurel Rd	
17. INFORMANT James Moyo Laurel Rd		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/7/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 5/7/58	22c. NAME OF CEMETERY OR CREMATORY Beachwood	22d. LOCATION (City, town, or county) (State) Durham N.C.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Smith		24a. REC'D BY REGISTRAR May 12 '58	24b. REGISTRAR'S SIGNATURE Arthur Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5622 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Loplat</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Locomo md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>GORMAN</i> Middle <i>Lee</i> Last <i>HIGGS</i>		4. DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7, 1908</i>
9. AGE (In years last birthday) <i>50</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farmers</i>	
11. BIRTHPLACE (State or foreign country) <i>Stromy co</i>		12. CITIZEN OF WHAT COUNTRY? <i>md</i>	
13. FATHER'S NAME <i>Herbert Higgs</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Anna Riel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>217-38-280</i>	
17. INFORMANT <i>Jacob Bowling Waldorf md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i> DUE TO <i>Acute Cardiac dilatation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Failure</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. 3 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Apr</i> , 19 <i>55</i> , to <i>May 13</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 9</i> , 19 <i>58</i> , and that death occurred at <i>9:30 p.m.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Johnson</i>		ADDRESS (Street, city or town, state) <i>L. Plata, Md.</i> DATE SIGNED <i>13 May 58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-16-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>	22d. LOCATION (City, town, or county) (State) <i>Charles md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Corehart Inc</i>		ADDRESS <i>Loplat md.</i>	
24a. REC'D BY REGISTRAR <i>Albrecht</i>		24b. REGISTRAR'S SIGNATURE <i>Albrecht</i>	
DATE <i>MAY 20 '58</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>
DATE OF DEATH <i>Jan 15 1920</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>
CAUSE OF DEATH <i>Myocardial Infarction</i>		DISEASE OR INJURY <i>Coronary Atherosclerosis</i>	
MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Teacher</i>	
RESIDENCE <i>123 Main St, Boston, Mass</i>		BIRTHPLACE <i>Massachusetts</i>	
DATE OF BIRTH <i>Jan 15 1875</i>		PLACE OF BIRTH <i>Boston, Mass</i>	
EDUCATION <i>High School Graduate</i>		MARRIAGE <i>Married</i>	
RELIGION <i>Protestant</i>		RACE <i>White</i>	
SIGNED BY <i>Dr. J. Smith</i>		WITNESSED BY <i>John Doe</i>	
DATE <i>Jan 15 1920</i>		PLACE <i>Boston, Mass</i>	

5623 CERTIFICATE OF DEATH

Reg. Dist. No. 05614

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CONSTANCE ELIZABETH HUNTT		4. DATE OF DEATH Month Day Year May 30 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1894
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edward Anderson Hunt		14. MOTHER'S MAIDEN NAME Harriett Simpson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT George Burch		Address Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO (c) CORONARY THROMBOSIS (Jan. - Mar. 1958)			INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 10 YEARS 6 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCTOBER 19 47 , to MAY 30 , 19 58 , that I last saw the deceased alive on MAY 30 , 19 58 , and that death occurred at 1:50 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Giffen		ADDRESS (Street, city or town, state) Box #65, HUGHESVILLE, MD	
PHYSICIAN'S NAME (Type) John H. Giffen		DATE SIGNED 6/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-2-58	22c. NAME OF CEMETERY OR CREMATORY Hunt Cem.	22d. LOCATION (City, town, or county) (State) Waldorf, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.	24a. REC'D BY REGISTRAR JUN 3 '58
		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5624 CERTIFICATE OF DEATH

05615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phy mem Hesth - LaPlata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>R.F.D. # 1</i>	
3. NAME OF DECEASED (Type or print) <i>BABY BOY KECKLER</i>		4. DATE OF DEATH <i>MAY 31 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 31 1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>med.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY <i>W A A</i>	
13. FATHER'S NAME <i>John Rollin Keckler</i>		14. MOTHER'S MAIDEN NAME <i>Wilma Inez Dancy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John R Keckler M.D.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Insufficient Oxygenation of blood</i> 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aspiration of meconium & amniotic fluid</i> DUE TO (c) <i>12 hours</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-31</i> , 19 <i>58</i> , to <i>5-31</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5-31-58</i> , 19 <i>58</i> , and that death occurred at <i>1:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V.B. Detton, M.D.</i>		ADDRESS (Street, city or town, state) <i>LA PLATA, MD.</i>	
PHYSICIAN'S NAME (Type) <i>V.B. DETTOR, M.D.</i>		DATE SIGNED <i>5-31-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-3-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>med Rest</i>		22d. LOCATION (City, town, or county) (State) <i>LaPlata med</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archer D. Laplata M.D.</i>		24a. REC'D BY REGISTRAR <i>W. S. Smith</i>	
ADDRESS		DATE <i>JUN 9 '58</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1918</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. PREVIOUS ILLNESS <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESSES <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>		69. SIGNATURE OF JURY <i>John Doe</i>	
70. SIGNATURE OF JURY <i>John Doe</i>		71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>		87. SIGNATURE OF JURY <i>John Doe</i>	
88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

RECEIVED
JAN 15 1918
BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5625 CERTIFICATE OF DEATH

05616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Oakley St Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakley	
c. LENGTH OF STAY IN 1b 9 months		18 X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE First THOMAS Middle NEALE Last		4. DATE OF DEATH May Month 28 Day 1958 Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1909
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 48	IF UNDER 24 HRS. Days 48 Hours 48 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Neal		14. MOTHER'S MAIDEN NAME Ruth Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-30-0009	
17. INFORMANT Nellie Neal		Address LaPlata, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of Bone 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary site uncertain. DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 3 mo.?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-23-58 , 19 58 , to 5-28-58 , 19 58 , that I last saw the deceased alive on 5-27-58 , 19 58 , and that death occurred on 5-28-58 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE V.B. Detton		ADDRESS (Street, city or town, state) La Plata, Md.	
PHYSICIAN'S NAME (Type) V.B. DETTOR		DATE SIGNED 5/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/58	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR JUN 2 '58		24b. REGISTRAR'S SIGNATURE W. Clarke	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5626 CERTIFICATE OF DEATH

Reg. Dist. No. 05617

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie First Parker Middle SHOTWELL Last		4. DATE OF DEATH May 20 Month May Day 20 Year 58	
5. SEX F	6. COLOR OR RACE W-S-W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 May 1903
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN Home	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Parker		14. MOTHER'S MAIDEN NAME UNIK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Killis F. Shotwell, Waldorf, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Respiratory Collapse DUE TO (b) Cardio-renal failure DUE TO (c) CUA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 May, 1958 , to 20 May, 1958 , that I last saw the deceased alive on 19 May, 1958 , and that death occurred at 2:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A Wooddy		ADDRESS (Street, city or town, state) La Plata, Md.	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODDY		DATE SIGNED 20 May 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/58	
22c. NAME OF CEMETERY OR CREMATORY Cedarville		22d. LOCATION (City, town, or county) (State) Cedarville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS	
24a. REC'D BY REGISTRAR MAY 23 '58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>Johns Hopkins</u></p>	
<p>5. Date of death: <u>Jan 1, 1950</u></p>		<p>6. Place of death: <u>Johns Hopkins</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Signature of informant: <u>John Doe</u></p>		<p>12. Signature of witness: <u>John Doe</u></p>	
<p>13. Signature of funeral home: <u>John Doe</u></p>		<p>14. Signature of cemetery: <u>John Doe</u></p>	
<p>15. Signature of health officer: <u>John Doe</u></p>		<p>16. Signature of coroner: <u>John Doe</u></p>	
<p>17. Signature of medical examiner: <u>John Doe</u></p>		<p>18. Signature of pathologist: <u>John Doe</u></p>	
<p>19. Signature of anatomist: <u>John Doe</u></p>		<p>20. Signature of embalmer: <u>John Doe</u></p>	
<p>21. Signature of undertaker: <u>John Doe</u></p>		<p>22. Signature of casket maker: <u>John Doe</u></p>	
<p>23. Signature of coffin maker: <u>John Doe</u></p>		<p>24. Signature of vault maker: <u>John Doe</u></p>	
<p>25. Signature of interment: <u>John Doe</u></p>		<p>26. Signature of burial: <u>John Doe</u></p>	
<p>27. Signature of cremation: <u>John Doe</u></p>		<p>28. Signature of donation: <u>John Doe</u></p>	
<p>29. Signature of other: <u>John Doe</u></p>		<p>30. Signature of other: <u>John Doe</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		c. LENGTH OF STAY IN lb 55 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 302 Strauss Ave		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head	
3. NAME OF DECEASED (Type or print) First Emma Middle Victoria Last Swann		4. DATE OF DEATH Month May Day 12 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1897 87 yrs.
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Chas. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Penny		14. MOTHER'S MAIDEN NAME Mary (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Cecil B. Swann		Address Indian Head, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pernicious Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank A. Susan		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank A. Susan M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/58	
22c. NAME OF CEMETERY OR CREMATORY St Charles		22d. LOCATION (City, town, or county) (State) Glymont, Md	
23. FUNERAL DIRECTOR'S SIGNATURE The HUNTT Funeral Home, Waldorf, Md		24a. REC'D BY REGISTRAR MAY 15 '58	
		24b. REGISTRAR'S SIGNATURE W. H. Leach	

MINISTER OF DEFENSE: CERTIFICATE OF DEATH

5628

CERTIFICATE OF DEATH

05619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Charles.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA.				c. LENGTH OF STAY IN 1b 17 years.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN HATHWAY TAYLOR				4. DATE OF DEATH May 11 1958			
5. SEX Male		6. COLOR OR RACE US-W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 July 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed.		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOHN SAMUEL TAYLOR				14. MOTHER'S MAIDEN NAME Emily Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes.		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO.		17. INFORMANT Son: John Hathway Taylor Address Ja. La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery atherosclerosis. DUE TO (c) 1 day.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1949 , to May 1958 , that I last saw the deceased alive on 10 May 1958 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur O. Woody M.D.				ADDRESS (Street, city or town, state) La Plata, Maryland			
DATE SIGNED 11 May 58							
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Rest		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				ADDRESS		24a. REC'D BY REGISTRAR MAY 15 '58	
						24b. REGISTRAR'S SIGNATURE W. Beaman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

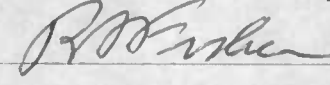


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07917

Reg. Dist. No.

5629

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Unknown b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Arehart Funeral Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First UNKNOWN Middle Last		4. DATE OF DEATH Month May Day 24 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. Newborn	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma probably due to birth trauma 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Unknown 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Unknown	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DATE SIGNED 5/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/9/58	
22c. NAME OF CEMETERY OR CREMATORY Balto. City Morgue		22d. LOCATION (City, town, or county) (State) 700 Fleet St., Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 		24a. REC'D BY REGISTRAR DATE JUL 21 '58	
ADDRESS 700 Fleet Street		24b. REGISTRAR'S SIGNATURE 	

9VVVVVVV XV V

CREMATED MORGUE 7-18-58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

